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To: Nursing NH 32

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Bureau of Quality Assurance

**Questions/Answers - Resident Assessment Instrument - Memo #2**

This is the second in a series of Bureau of Quality Assurance memos that addresses questions about the Resident Assessment Instrument (RAI) and the Minimum Data Set (MDS).

## GENERAL QUESTIONS

**How do you complete the MDS when the resident does not want to give any information and refuses to have his/her family give information? Does the resident have the right to refuse to give information that is necessary for his/her care?**

When completing the MDS, the resident is a primary source of information. The facility is responsible for assuring that both residents and their families are actively involved in the information-sharing and decision-making process.

Good communication is essential. It is important to explain to residents, their families and significant others that the purpose of gathering information is to make good clinical decisions. Their willingness to cooperate will be facilitated by developing rapport and building trust. If a resident refuses to give the necessary information to a facility, the facility needs to ask why. Sensitive staff judgment will facilitate the gathering of resident-specific information.

Performing an accurate and comprehensive assessment requires gathering information about the resident from a variety of sources. When completing the MDS, multiple sources of information should be used, including: 1) review of the resident's record; 2) observation of the resident; and 3) communication with the resident, direct-care staff, licensed professionals, the resident's physician, and the resident's family.

When information is not available, data elements can be coded either with a "circled" dash or an "NA." This coding indicates that the above sources have been used and the information is **not** available.

**What number should be coded at Section AA, Item 6, Facility Provider No. (a. State No.)?**

Each facility received a unique facility number in a Bureau of Quality Compliance Memo (BQC-96-014). When completing your MDS forms, use this number as your facility's **'State No.'** on the MDS *Basic Assessment Tracking Form,* Section AA, Item 6a.

**In our facility, the restorative-care nurse assistants participate in collecting assessment and screening information for the MDS, but do not perform the comprehensive assessments triggered by the RAI. Can these restorative-care nurse assistants record their information on the MDS?**

Yes, facilities have the flexibility to determine who is competent to participate in the assessment process, as long as it is accurately conducted. A facility may assign the responsibility for completing portions of the MDS to a number of qualified staff. A nurse assistant is not precluded from completing sections of the MDS.

Federal regulations require that the RAI assessment is conducted or coordinated: 1) with the appropriate participation of health professionals, and 2) by an RN who signs and certifies the completed assessment. Completion of the RAI is best accomplished by an interdisciplinary team that includes facility staff with varied clinical backgrounds.

**If a resident who is discharged with no return anticipated does return several months later, is the resident considered a re-entry or a new admission for MDS purposes?**

The resident in this example would be considered a new admission. This means that a complete RAI would be required, including the *Basic Assessment Tracking Form* and the *Background (Face Sheet) Information at Admission Form*. If the resident had been in the facility during the past 15 months, the facility would be required to bring previous MDS information forward into the resident's current medical record.

**Is it necessary to do any other quarterly assessments or annual assessments besides the MDS?**

Because the RAPs focus on the functional aspects of a triggered condition, they are not comprehensive **clinical** assessment tools. The clinician needs to determine if the RAPs are sufficient to evaluate the resident's condition. There are many assessment tools and clinical practice guidelines, in addition to the RAPs, that can contribute in the clinical decision-making process.

The MDS is not a comprehensive assessment. It is a core set of screening and assessment information about a resident's clinical and functional status that forms the foundation of a comprehensive assessment. The MDS yields information about the resident's functional status, strengths, weaknesses and preferences. Use of the RAI triggering logic directs the clinician to the Resident Assessment Protocols (RAPs) that provide guidance for further assessment. The RAPs are accepted practice standards for the nursing home population.

**At the RAI training programs, Bureau of Quality Compliance staff indicated that the care plans need to be current, but that the MDS does not need to be current. I was under the impression that the MDS must be current at all times, please explain.**

The information given at the Bureau of Quality Compliance training program is correct. The MDS information represents the resident's performance and health status during a specific time-period, i.e., the assessment reference period. Once completed, the information does not need to be changed to reflect the resident's current status unless there is a significant change of condition that meets the requirement for a new *Full Assessment* MDS. A *Full Assessment* MDS is completed at least annually, and the *Quarterly* MDS is completed at 3-month intervals between full MDSs. The information on previous MDSs is used for comparative analysis.

Care plans direct the resident's care on a daily basis. A care plan needs to be current in order for the facility to give the appropriate care and services to maximize the resident's potential and ability to reach identified goals. Care plans may change frequently between resident assessments required by the RAI process.

## AUTOMATION AND COMPUTERIZED MEDICAL RECORDS

**When will nursing homes be required to transmit MDS information to the State?**

The Health Care Financing Administration (HCFA) is moving forward on plans that will require certified nursing facilities to transmit MDS information to the state agencies. HCFA expects the RAI final regulation, requiring the transmission of MDS information, will be published by January or February 1997, with an effective date of July 1997. HCFA has indicated that by the end of 1997 all states will be able to accept MDS data from nursing facilities.

Currently, HCFA is testing MDS automation applications in four states: California, Minnesota, Missouri and Colorado. These states are referred to as MDS *beta test sites*. During the first phase of this project, HCFA will evaluate the data management components of the test systems, i.e., the ability of states to: 1) receive information from nursing facilities, 2) validate information with standardized edits and 3) post MDS information to a HCFA repository. In the second phase of testing, MDS automation will include implementation of the analytical applications of the MDS data.

The Wisconsin Center for Health Statistics (CHS), in collaboration with the Bureau of Quality Assurance, is also testing MDS information that is being voluntarily submitted to CHS. The purpose of this project is to test MDS software and to evaluate the capacity of facilities to transmit MDS data to the state agency.

**Our facility is transitioning from a paper medical record system to an automated medical record system. We use MDS worksheets to gather MDS data and then have a non-clinical staff person data enter the information into an automated MDS record. Who is required to sign the MDS form when the person who is data entering the information is not the professional staff person who gathered the data and completed the MDS worksheets?**

The transition to an automated medical record system creates new challenges. It is not the intent of the RAI process to increase the burden of documentation, or to require a dual system to complete the MDS. The intent of an automated medical record system is to have qualified staff enter data into the record using authenticated access codes and signatures.

The situation described here requires the person who is entering the data to sign at Section R, Item 2, and to indicate a data entering function. An RN assessment coordinator would need to sign the MDS form to certify completion and accuracy of the assessment. Others who have completed portions of the MDS would sign and indicate which portion of the MDS they completed and when. Since it is inappropriate to backdate medical record documentation, staff would sign using the current date, referencing back to the date when the information was entered onto the MDS worksheets for data entry.

## SECTION B - COGNITIVE PATTERN

**What is the definition of comatose when coding at Section B, Item 1? Is a 3 on Rancho-scale considered comatose?**
The *Rancho Los Amigos Cognitive Scale* is a commonly used tool to measure neuro-status. When using the *Rancho Los Amigos-Cognitive Scale*, a Level I determination (no response to pain, touch, sound or sight) would be considered comatose.

Clinical nursing literature describes semi-comatose to include responding only to pain and having only reflex activities. Therefore, anyone who is determined to be above Level I on the *Rancho Los Amigos Cognitive Scale* should be considered semi-comatose. If the resident is semi-comatose, the clinician/practitioner would code zero (0) and proceed to complete the MDS without utilizing any skip pattern.

Another commonly used scale for assessing neuro-function is the *Glasgow Coma Scale. A* score of three (3) on this scale would be considered comatose.

**How should you code the MDS for a brain-injured resident who shows signs of delirium, and mood and behavior patterns that are a consequence of the brain injury, rather than a true delirium or depression?**

Code the MDS as accurately as possible according to the resident's **actual** performance. The coding of data elements should be consistent with the coding definitions in Chapter 3 of the *Long Term Care Resident Assessment Instrument Users Manual,* October 1995.

If a RAP is triggered, the comprehensive assessment of the resident's condition should identify if the behavior symptoms are specifically related to the brain injury, or if these behavior symptoms represent a treatable delirium. The assessment documentation will provide the reader further information about the clinical picture of the resident and the rationale for care.

For example, if on the admission assessment a resident presented with a deteriorated mood state in the last 90 days that was related to a brain injury that occurred 2 months previously, Section E, Item 3 is coded as a two (2). The RAPs for **Mood and Psychotropic Drug Use** will trigger the need for further assessment. If the resident is not on any psychotropic drugs, further assessment would focus on the appropriate use of a psychotropic medication as an appropriate treatment option. If the resident does not have any clinical signs or symptoms of delirium, there has been no acute change indicating delirium, and the resident's mood remains at the same level assessed at the time of preadmission, then delirium can be ruled out as an issue. Assessment documentation would provide supporting evidence of the assessment that, based on clinical judgment, the resident's behavioral symptoms are present due to the brain injury and not a delirium.

## SECTION E - MOOD AND BEHAVIOR

**When completing the full or quarterly MDS assessment, if the resident has not wandered during the assessment reference period but has wandered in the past, and wandering is addressed on the plan of care, what would be coded at Section E, Item 4a, a zero (0) or a one (1)?**

You would code a zero (0) at section E, Item 4a, because this code relates to the resident's actual performance during the reference period. If wandering has been a past problem, coding a
zero (0) does not indicate that wandering is no longer a problem. Analysis of this data element could indicate that the plan of care has been effective, that the resident has adapted to his/her new environment and feels safe, or that wandering episodes have decreased in frequency. If this is a problem or concern that has been addressed on the resident's plan of care, it should be reviewed in light of the resident's current status and the plan revised, if indicated.

## SECTION G - PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

**A resident is in a reclining geri-chair because he cannot sit upright for any extended period of time, and this type of chair and positioning best meets the resident's needs. Is this resident considered to be bedfast?**

Not necessarily. If the resident remains in his room when in the reclining chair, the resident would be considered bedfast. However, if the chair enables the resident to attend activities and eat in the dining room, then the resident would not be considered bedfast.

**Must the *ADL-Supplement,* (located in the RAP for ADL/Functional Rehabilitation Potential) be completed and a copy put in the resident's medical record when this RAP has been triggered?**

No. The *ADL Supplement* is an assessment tool that many practitioners have found helpful when doing a comprehensive assessment of a resident's ADL functions. There may be other similar clinical tools that could also be used. The *ADL Supplement* could be used as a worksheet with clinically-relevant assessment information documented in the medical record or, the facility could choose to use a completed supplement as part of its medical record information.

## SECTION H - CONTINENCE IN LAST 14 DAYS

**If a resident has been taught to call for help when he/she needs assistance to get to the bathroom, would this be considered a bladder training program when coding at Section H, Item 3b?**

If the goal is to teach the resident to delay voiding and to increase bladder stability, then it would be coded as a bladder training program. However, if the goal is have the resident call for help with *any* urgency to void (with the goal of keeping the resident dry) it would not be considered a bladder retraining program. In this latter case, the focus is on the resident, not the bladder. Use your clinical judgment when making this determination.

## SECTION J - HEALTH CONDITIONS

**Must the facility weigh each resident at the beginning and at the end of the seven (7) day assessment reference period when coding indicators of fluid status at Section J, Item 1a?**

There is no requirement to weigh each resident at the beginning and end of the assessment reference period for this data element. A majority of residents do not require that frequency of weighing. If this frequency is not clinically indicated, the data element would be left blank.
However, for residents at high risk for fluid status problems, it may be clinically indicated to weigh the resident with this frequency to assess his/her clinical condition. Accurate coding at this data element would require weighing within the assessment period.

**Does an MD have to identify a prognosis of less than 6 months to live in order to check Section J, Item 5c - *End-stage disease, 6 or fewer months to live*?**

There does not need to be a diagnosis of terminal illness documented in the medical record to check this data element. However, the resident should present with, and the medical record should substantiate, a disease diagnosis and course of deteriorating clinical condition that leads to this determination.

## SECTION K - ORAL/NUTRITION

**Is a high-calorie/high-protein diet considered a planned weight change program if the reason for the diet is related to a decubitus ulcer?**

No, based on the information in the example, the diet's goal is to provide additional protein for building and repairing tissue and additional calories for protein sparing, rather than to specifically increase or decrease weight. This would be coded at Section K, Item 5e-Therapeutic Diet.

**Is a no-added-salt (NAS) diet considered a therapeutic diet?**

Yes.

**How do you evaluate *complaints about food taste*, and *hunger* at Section K, Items 4a & b, for a resident with severe dementia?**

Changes in appetite and/or changes in eating behavior are often signs and symptoms of serious problems in the elderly population (whether or not a person has dementia) and are important factors in assessing a resident's oral and nutritional status. These areas are certainly easier to code when a resident is cognitively intact.

When coding these data elements for residents with severe dementia, code on the basis of the resident's performance, as observed by the resident's behaviors. For example, a resident may exhibit hunger by taking food from other residents' food trays, trying to eat non-food items, or acting anxious or demanding when foods are served. A change in a resident's eating behavior may be noted when a resident refuses to eat foods that were previously well-liked, and could represent a change in taste. Further assessment may reveal that these behaviors occurred after a new medication was ordered, and that the medication is noted to alter appetite and/or taste perceptions. Use your best clinical judgment based on your knowledge of the resident. Nurse aides and family members are excellent resources in obtaining this type of information about a resident.

## SECTION N - ACTIVITY PURSUIT PATTERNS

**I'm still confused on the activity triggers where it takes two items to initiate the trigger. For example, Section N, Item 1a-*awake in the morning* is checked and Item 2- time involved in activities is coded as a zero (0)-*most or more than 2/3 of time.***

A check at Section N, Item 1a-*awake in the morning* and a zero (0) coded at Section N, Item 2 will trigger the activities RAP. This will require a review of the activity plan with consideration given to the possibility of the resident being over-programmed for activities.

This trigger is considered a 'prevention of problem' type of trigger. The triggering indicates a **potential** for concern. A comprehensive assessment of the resident's activity program in relationship to his/her current health status will indicate what actions are necessary to best meet the resident's needs. For example, when a resident spends most of his/her time in activities, is consideration being given to other rehabilitation goals? As a result of morning activities, is the resident too fatigued to attend physical therapy sessions in the afternoon?

**When coding on the MDS *Quarterly Assessment*, what is required when Section N, Item 1a is checked *resident awake all or most of time-mornings* and Item 2 is coded a zero (0) *involved in activities most of the time*? When doing a full MDS, would this trigger the activities RAP?**

The MDS *Quarterly Assessment* does not require that the facility complete the RAPs. However, the subset of data elements on the MDS *Quarterly Assessment* focuses on critical indicators related to the resident's conditions. Facility staff need to use this information to adjust plans of care and/or to make determinations as to whether the resident is experiencing a significant change of condition that will require a full RAI assessment.

In the above example, you would want to review the resident's current activity plan and determine if it meets the resident's needs. Does the program enhance the resident's quality of life and assist the resident in achieving his/her highest potential? Does the activity program coordinate with the resident's rehabilitation goals and objectives? Are the activities appropriate or do they need modification? Do the activities challenge the resident's potential or hinder progress toward rehabilitation goals?

**In our facility we implement the RAP for activities on all residents, whether the RAP is triggered or not. Is this an appropriate practice?**

The RAPs are designed by professional practitioners and represent accepted standards of practice. The RAP about activities provides activity professionals and others a way to focus interventions with a greater likelihood for successful resident outcomes. Since activity programming is identified as a universal need, it would not be wrong to apply this practice standard to all residents.

The RAI is intended to identify resident-specific areas that need comprehensive assessment. The rationale is to focus on resident-specific needs rather than on all potential needs when there is no evidence of a problem or concern.

## SECTION V - RESIDENT ASSESSMENT PROTOCOL SUMMARY

**Does all the information identified at the 'location of information' on the RAP form need to stay in the active medical record for the 15-month period required for the MDS?**

In a paper record-keeping system, assessment documentation referenced on the Resident Assessment Protocol Summary (RAPS) form can be gleaned from the medical record, but must be 'readily accessible' to the interdisciplinary care team and others who need access to the record. A good rule-of-thumb in determining whether the information is 'readily accessible' is to consider whether or not a pool nurse on the night shift has access to the medical record information. If not, the overflow medical record information is probably not readily accessible.

For automated record-keeping systems, there will be new questions about the functions, capacity, access to and storage of medical records.

## QUARTERLY REVIEWS

**When completing Section Q, Item 2, of the MDS *Quarterly Assessment,* does coding a two (2)*, deteriorated-receives more support,* for overall change in care indicate a need for a significant change of condition reassessment?**

Not necessarily. While the resident's condition may have declined, it may not meet the definition of a change of condition that requires a new full RAI. The medical record should have supporting evidence that the decline has been evaluated and the resident's condition is not a significant change requiring a full RAI.

**Please explain the Assessment Reference Date, Section A, Item 3, for the *Quarterly Assessment.***
The concept for the assessment reference period is the same for the quarterly and the full assessments. The facility identifies a date that is the end point in the MDS assessment process. All persons completing the quarterly MDS use the identified reference period so that all assessment items refer to the resident's objective performance and health status during the same period of time. The date indicated at Section R, Item 2b, is the date that the quarterly review has been certified as completed by an RN, and is the 'official date' of the *Quarterly Assessment*.

**When completing the *Quarterly Assessment,* if there is no change in the resident's status based on the MDS data elements, is it necessary to do any further documentation?**

The *Quarterly Assessment* is used to track the resident's status between comprehensive assessments and to monitor critical indicators of the gradual onset of significant changes in the resident's status. The resident's status must be assessed for each of the key mandated items on the *Quarterly Assessment*.

When you have completed the *Quarterly Assessment,* even when there has been no change, the responses should prompt questions about the resident. For example, is the resident functioning at his/her highest level? Should the resident have made progress in areas that are identified on the plan of care? Is the current plan of care challenging the resident's abilities? Could changes in the plan of care facilitate improvements in resident's physical status or quality of life? Are there areas of concern that are not identified by the MDS quarterly data set that are pertinent to the resident? Facilities are responsible for assessing areas that are relevant to individual residents regardless of whether these areas are included in the RAI.

Documentation should present a picture of the resident's progress, including responses to treatment, changes in condition, responses to the plan of care, progress towards goals, and other pertinent information about the resident that the care team should know. The clinical records must contain enough information to demonstrate that the facility knows the status of the individual, has adequate plans of care and provides sufficient evidence of the effects of the care provided.

## ORDERING INFORMATION

**Long Term Care Resident Assessment Instrument User's Manual:** The cost per copy, including postage, is $8.20 for tax exempt organizations, and $8.51 for all others; walk-in costs are less postage. Please make your check payable to the **Division of Supportive Living** and mail to:

Division of Supportive Living
Bureau of Quality Assurance
Attention: Gary Zimmerman
P.O. Box 309
Madison WI 53701

**MDS Version 2.0 Forms:** The following forms can be obtained from the Bureau of Quality Assurance:

1. Basic Assessment Tracking Form
2. Background (Face Sheet) Information at Admission Form
3. Full Assessment Form - (top or side mount)
4. Quarterly Assessment Form
5. Resident Assessment Protocol Summary Form

For a Forms/Publication Requisition, please call Barb Carey at (608) 267-1446.

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